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Workplace Phobia

Original Article

Workplace Phobia – A first explorative study on its relation to established anxiety disorders, sick leave, and work-directed treatment

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Abstract

Objective:

Workplace phobia is defined as a phobic anxiety reaction with symptoms of panic occurring when thinking of or approaching the workplace. People suffering from workplace phobia regularly avoid confrontation with the workplace and are often on sick leave. The specific characteristics of workplace phobia are investigated empirically in comparison to established anxiety disorders.

Method:

230 patients from an inpatient psychosomatic rehabilitation hospital were interviewed concerning workplace phobia and established anxiety disorders. Additionally, the patients filled in self-rating questionnaires on general and workplace phobic symptom load. Subjectively perceived degree of work load, sick leave and therapy participation were assessed.

Results*:*

Participants with workplace phobia reached significantly higher scores in workplace phobia self-rating than did participants with established anxiety disorders. A similar significant difference was not found concerning the general psychosomatic symptom load. Workplace phobics were more often on sick leave than patients with established anxiety disorders.

Conclusions:

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Workplace phobia can occur as an alonestanding anxiety disorder. It has an own clinical value due to its specific consequences for work participation. Workplace phobia requires special therapeutic attention and treatment instead of purely “sick leave” certification.

Keywords

Workplace phobia, anxiety disorders, sick leave, return to work, work ability, participation disorders

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Introduction

Although widespread research has been carried out in the field of workplace and mental health, the term "workplace phobia" (Haines, Williams, & Carson, 2002; Linden & Muschalla, 2007b) appears as a new clinical concept.

Conventional anxiety disorders and workplace phobia

According to the American and international diagnostic classification systems of mental disorders DSM-IV (APA, 1994) and ICD-10 chapter F (WHO, 1992), different forms of anxiety disorders are known. Although they are characterised by different leading symptoms - that may be dominantly cognitive, or physiological, or emotional symptoms - they all have in common the relatedness to more or less specific anxiety-provoking stimuli. Anxiety-provoking stimuli are learned by model or conditioning experiences (MacDonald, Colota, Flamer, & Karlinsky, 2003), or they are biologically predisposed, like in spider phobia (Gerdes, Alpers, & Pauli, 2008) or acrophobia.

Workplace phobia refers to a specific but also very complex stimulus. Workplaces contain potentially anxiety-provoking factors which may provoke different primary workplace-related anxieties (Linden & Muschalla, 2007a), and these, in a generalization process, may result in a workplace phobia.

Workplace and anxiety

Workplaces contain stimuli which are especially prone to provoke anxiety: There are social hierarchies (Thomas & Hynes, 2007), conflicts with colleagues or superiors often described in terms of mobbing or bossing (Yildirim & Yildirim, 2007); uncertainty about the professional future and keeping the job (Eshel & Kadouch-Kowalsky, 2003; Strazdins, D´Souza, Lim,

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Broom, & Rodgers, 2004); demands for achievements which may povoke perception of overtaxation or insufficiency (Browning, Ryan, Thomas, Greenberg & Rolniak, 2007; Turnipseed, 1998). There can be environmental and physical endangerments (MacDonald, Colota, Flamer, & Karlinsky, 2003; Munir et al., 2007), or structural changes (Campbell & Pepper, 2006). Mental disorders and anxiety in the workplace can have negative influence on work participation, this is to be seen in either sick leave, or lost productivity or reduced safety at work (Haslam, Atkinson, Brown, & Haslam, 2005a,b; Linden & Weidner, 2005).

Workplace phobia

Workplace phobia is characterized by a phobic anxiety reaction towards the workplace. There is a panic-like physiological arousal when thinking of the workplace or approaching. The person shows clear avoidance behavior towards the workplace. In contrast to a specific phobia according to DSM-IV, it is not obligatory that the person perceives his/her fear as "exaggerated" or "senseless" (for further details on the diagnostic criteria see Muschalla, 2009).

A first experimental study on workplace phobia (Haines et al., 2002) investigated the physiological mechanisms of workplace phobia. The diagnosis of workplace phobia was given by clinical judgement. Criteria for workplace phobia diagnosis were

- self-reported intensive fear when approaching or passing the workplace,
- inability to enter the workplace because of severe anxiety symptoms and
- reduction of symptoms when leaving the workplace.

Participants with workplace phobia demonstrated elevated heart rate response and subjective reports of fear that distinguished them from the non-phobics.

Avoidance

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Avoidance is an important diagnostic criterion (DSM-IV: Specific phobia; APA, 1994) of phobic anxiety disorders and functions as a classical but dysfunctional coping strategy in anxiety patients. In workplace phobia, differently from specific phobias (Greenberg et al., 1999), avoidance often manifests in long-time sick leave, and can result in quitting the workplace or early retirement.

Therapeutical requirements in workplace phobia

In all behavioral therapeutic treatments of phobias exposition is an important method (Hand & Wittchen, 1986; Linden & Hautzinger, 2005). The special problem about the therapy of workplace phobia is that in-vivo-expositions with anonymous graded approaching are difficult or even impossible to be realised. The conditions at the workplace cannot be controlled by the therapist so that a planned and dosed exposition is not possible. Under such conditions there is even the risk of strengthening the phobia. Generally utile therapy techniques are descriptions and analysis of situations and behavior, the development of coping strategies, the revision of self-imposed demands, principles of reframing and anxiety management, clearing of conflicts and exposition in sensu (Linden & Hautzinger, 2005). A specific therapeutic instrument may be a "therapeutic working trial" (Beutel, Kyser, Vorndran, Farley, & Bleichner, 1998; Hillert, Lehr, & Pecho, 2001). The idea is to send patients on a hospitation in chosen workplaces similar to the professional setting in which the patient´s problems occurred.

Objectives

Workplace phobia is investigated concerning its specific clinical characteristics. Observer- and self-rating perspectives are used.

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1. The first aim is to investigate "workplace phobic anxiety" concerning its relatedness with "established anxiety disorders"[1] and perceived general psychosomatic symptom load, including general (not-work-related) anxiety.
2. Secondly, work-participation problems are regarded: Sick leave measures will be used as objective criteria of workplace absence.
3. Thirdly, in respect to treatment, frequencies of participation in work-directed therapy units in a psychosomatic rehabilitation program are investigated.

A sample of psychosomatic rehabilitation inpatients has been investigated. This group of patients is especially suitable for an exploratory investigation concerning the interaction of work-problems and mental disorders. The study does not aim at epidemiological findings, but finding out what characterizes workplace phobia in comparison to established anxiety disorders.

Method

Procedure

It was a cross-sectional explorative study including patients from the department of behavior therapy and psychosomatics of a rehabilitation clinic. Participants were interviewed with a structured diagnostic interview (MINI and Mini-WAI, described below) and filled in questionnaires on workplace problems (*Workplace Phobia Screening,* WPS, original: "Arbeitsplatzphobieskala"; Muschalla & Linden, 2008) and perceived general psychosomatic symptom load (*Symptom Checklist*, SCL-90-R; Franke, 1995) a few days after admission.

[1] "Established anxiety disorders" means the conventional anxiety disorders according to the ICD-10 or DSM-IV which are not specifically related to the workplace.

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Participants were free to participate or not after having been informed that their answers were used for scientific purposes only. Data were analysed anonymized.

Additionally, data from the routine diagnostic in the clinic has been used for analysis, that is duration of sick leave in the past 12 months in sum, and participation in work-related therapy units during the patients´ rehabilitation treatment.

Clinical setting

In this clinical setting patients are admitted because their mental disorder has taken a chronic course, e.g. persistent anxiety disorders or recurring depression, or has caused prolonged periods of sick leave. Psychosomatic patients are on rehabilitation stay in the clinic on average for six weeks. The program consists of single- and group-psychotherapy which are carried out by medicines and psychological psychotherapists in co-operation with sport-therapists, social workers and ergo-therapists. Concerning the treatment of workplace problems and in view of professional reintegration, patients can participate in additional work-directed therapy units: intensified consultation with social workers in single setting, intensified psychotherapeutical treatment in single setting with focus on the topic workplace, therapeutic working trials at real workplaces outside the clinic, three additional group therapies on “time management”, “conflict management”, and “work application training”.

Participants

The sample of the study included 230 patients. 71% of the interviewed were women, the average age was 46,9 years. 94% of the participants were employees in their current or last workplace, 3,5% were high qualified leading employees, 2,5% were self-employed. 25% of the explored patients were out of work at the time of their stay, the rate was higher in women

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than in men. 66% of the patients had a completed professional training. Only 6% had no professional certificate, 24% in contrast had a university diploma.

Men were more often working in technological domains (38%), whereas women were mainly employed in office jobs and public service domains (30%) and health care professions (18%). 40% of the patients were on sick leave before admission, 25% even longer than 20 weeks.

Instruments

The *Workplace Phobia Screening* (WPS; Muschalla & Linden, 2008) (Table 1) is a self-rating scale designed to measure workplace phobic anxiety and avoidance behaviour with 13 items. It has been derived from the *Job-Anxiety-Scale* (JAS; Linden, Muschalla & Olbrich, 2007) covering different dimensions of workplace-related anxiety. Psychometric properties of the WPS were tested in a psychosomatic inpatient sample. The split-half reliability was 0.97, Cronbachs alpha 0.96. The items are rated on a Likert-scale: "0 = no agreement" to "4 = full agreement". The mean score is relevant for data anylysis. The screening has been validated with structured diagnostic interviews as criteria (Linden & Muschalla, 2007a; Sheehan et al., 1994). The *Workplace Phobia Screening* is given to the patients with the title „Questionnaire on workplace problems" which examines „behaviour, thoughts and feelings which can occur in relation to the workplace".

[insert table 1 about here]

The *Symptom Checklist* in revised version (Franke, 1995) is a self-rating questionnaire which measures subjectively perceived general psychosomatic symptom load within a period of seven days. It contains nine different subscales: somatization, compulsiveness, unsureness in social contacts, depressive tendencies, general anxiety, aggressiveness, phobic anxiety,

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paranoid thinking and psychotizism. Patients are asked to rate 90 items concerning symptoms they are suffering from on a scale from 0 (never occurring) to 3 (occurring heavily).

The *MINI International Neuropsychiatric Interview* (Sheehan et al., 1994) is a standardized diagnostic interview stating diagnosis of the established mental disorders according to DSM-IV (APA, 1994), e.g. depression, anxiety disorders, adjustment disorders, addiction disorders. "Established anxiety disorders" assessed in this study are: posttraumatic stress disorder, agoraphobia, panic disorder, obsessive compulsive disorder, social phobia, hypochondriasis, generalized anxiety disorder. An additional *Mini-Work-Anxiety-Interview* (Mini-WAI) (Linden & Muschalla, 2007a) was designed for the assesment of different workplace-related anxiety qualities and workplace phobia, the latter being the most severe form of workplace-related anxiety. The interview has good psychometric properties, the cappa coefficient for interrater-reliability was 0.89. The criteria for the research diagnosis of "workplace phobia" are listed in table 2.

[insert table 2 about here]

In the Mini-WAI interview and in the "Questionnaire on workplace problems" patients were asked to refer to their current or – if they were currently unemployed – to their last workplace.

Additionally, patients were asked for a global rating to which degree on a scale from 0-100 their "workplace caused or forced" their current health problems ("work load" rating).

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Data analysis

Data were analyzed with SPSS-PC version 12.0. Relative frequencies were calculated and onedimensional variance analysis (ANOVA) were used to investigate differences between independent groups of participants. All statistical tests were two-sided.

Results

Workplace phobia and conventional anxiety disorders

Out of the 230 interviewed, 56,5% got a diagnosis of any anxiety disorder from the diagnostic interviews. 50,9% had a diagnosis of at least one established anxiety disorder in the MINI, i.e. posttraumatic stress disorder, agoraphobia, panic disorder, obsessive compulsive disorder, social phobia, hypochondriasis, generalized anxiety disorder. 17% patients fulfilled the criteria of workplace phobia in the Mini-WAI.

[insert table 3 about here]

From those patients with established anxiety disorder (table 3), 19,7% had a comorbid workplace phobia. From those patients with workplace phobia, 59% had at least one established anxiety diagnosis.

On the other hand, from those patients without established anxiety disorder, 14,2% had a diagnosis of workplace phobia; from those patients without workplace phobia, 49,2% had an established anxiety disorder.

Workplace phobic and general psychosomatic symptom load

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The four groups of patients with different comorbitity pattern (table 4) did not show significant differences concerning age, gender, duration of current or last employment, number of colleagues and superiors the person regularly worked together with, number of working hours and number of overwork hours per week, and degree of professional qualification.

[insert table 4 about here]

In all dimensions of general psychosomatic symptom load (SCL-90-R), patients with "workplace phobia" did not differ significantly from patients with "established anxiety disorders without workplace phobia". However, in workplace phobic symptomatic, patients with "workplace phobia" had significantly higher scores than patients with "established anxiety disorders".

In most of the general psychosomatic symptom load dimensions, except depression and psychotizism, patients "without established anxiety disorders and without workplace phobia" had significantly lower scores than patients with "established anxiety disorder". However, concerning workplace phobic symptomatic, these two groups of patients did not show significant differences in their self-reported symptom load.

Work participation and work load

Table 5 shows the differences between the four groups concerning perceived work load and work-related participation problems, i.e. sick leave.

[insert table 5 about here]

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70% and more of the patients with “workplace phobia” were on sick leave before admission into rehabilitation, whereras this was true in less than 40% of those patients without workplace phobia. There were no differences between patients with “established anxiety disorders” and patients “without any anxiety disorder”.

There is also a trend that patients with workplace phobia had been longer on sick leave in the past 12 months than patients with established or without anxiety disorders.

Participation in work-directed treatment units

Table 6 shows the percentages of patients within each group who participated in work-directed treatment units.

[insert table 6 about here]

Nearly all of the workplace phobic patients participated in work-directed treatment units during rehabilitation, whereas this rate was tendentially lower in those patients without workplace phobia diagnosis.

Workplace phobic patients participated significantly more often in a work application training than patients without workplace phobia, and the topic work(place) was more often a focus topic in consultation with social worker and psychotherapist.

Discussion

Research on the relation between work and mental health has traditionally focused on work stress, burnout, anxiety and depression in the workplace (Haslam, Atkinson, Brown, Haslam**,** 2005ab; Hobson & Beach, 2000; Kawakami et al., 1996**;** Maslach & Jackson, 1981) and their connection with work performance (Bakker, van Emmerik, & van Riet, 2008; O´Brien, Terry,

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& Jimmieson, 2008). Thereby anxiety has been operationalised as anxiety in general, like conceptualised in the state-trait anxiety model (Spielberger, Laux, Glanzmann, & Schaffner, 1981), or in terms of established anxiety disorders according to DSM-IV or ICD-10. In this study, workplace phobia has been defined and operationalised as a specific workplace phobic anxiety and has been investigated with a differential diagnostic perspective in order to find out whether it can be distinguished from established anxiety disorders.

Workplace phobia and conventional anxiety disorders

As the results from the diagnostic interviews show, workplace phobia can be distinguished differential-diagnostically from established anxiety disorders. A person may have an established anxiety disorder, but must not simultaneously suffer from workplace phobia, and vice versa.

However, workplace phobia is not always completely independent from established anxiety disorders as there was a number of patients affected from both. This fits to the general finding that mental disorders including anxiety disorders often appear in comorbidity (Jacobi et al., 2004).

In case of comorbid "workplace phobia and established anxiety disoders", the question of etiology arises and should be discussed: What may explain the comorbidity of workplace phobia and established anxiety diorders? Within a multidimensional etiology model (Muschalla, 2008), different qualities of primary anxieties can potentially lead to workplace phobia as a final severe anxiety syndrome. From anxieties which have first and originally manifested at the workplace, a complex system of phobic behavior may develop which exceeds the workplace and generalizes. Thus a primary workplace phobia may result in an agoraphobic symptomatic, going beyond the domain of workplace, with avoidance of public places. Thereby often the central fear is to meet colleagues or superiors. However, also another course is possible: primary established anxiety or other mental or somatic disorders

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not originally related with the workplace might cause special problems at work and trigger anxiety and avoidance behavior in the context of the workplace. In that sense, workplace phobia appears as a complication of an underlying primary disorder or vulnerability, whereby the workplace phobia syndrome obtains a specific clinical value.

Workplace phobic and general psychosomatic symptom load

The results also show that there can be made not only a qualitative, but also a quantitative differentiation between anxiety in general and workplace phobic anxiety:

Workplace phobics compared with not-workplace phobic patients showed higher scores in workplace phobic symptoms, but not in general psychosomatic symptoms. That means people differentiate between psychosomatic symptoms (and anxiety) in general and specific - here: workplace-related - anxiety. This can be seen as a contribution to the divergent validity of the concept of workplace phobia as distinguishable from established anxiety disorders.

Work participation: Workplace phobia and the meaning of sick leave

The direct association with work participation disorders, here measured with the objective criteria of sick leave duration and sick leave at admission, can be seen as another specific characteristic of workplace phobia. The higher rate of sick leave at admission and the longer durations of sick leave in workplace phobics compared to patients with established or without anxiety disorder can be explained due to the fact that avoidance through sick leave makes sense in case the anxiety-provoking stimulus is the workplace. In fact, in established anxiety disorders, there have been incoherent findings on sick leave: on the one hand, anxiety disorders were found in connection with increased sick leave: Nieuwenhuijsen et al. (2006) pointed out to the diagnosis of anxiety or depression being useful as a predictor for a longer time until return to work. On the other hand, Sanderson & Andrews (2006) have found that anxiety and depression also lead to reduced productivity at work. Greenberg et al. (1999)

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found that anxiety disorders - except (established) simple phobias – were associated with limitations in work performance.

Participation in work-directed treatment units

Workplace phobic patients within this sample did most often participate in a work application training group. This treatment choice can be seen as a therapeutic reaction on the problem which is often reported by workplace phobic patients, namely their perceived impossibility to return to a former workplace. In that respect, the therapeutical aim should be rather future-directed and ressource-oriented, and focus on starting search for a new workplace. Accordingly, "workplace" is often the main topic in socio- and psychotherapy with workplace phobic patients. Summarizing, workplace phobia therapy should be covering two aspects: behavioral orientation towards work-related *ressources and competencies*, as well as *confrontation-in-sensu* with the phobic stimulus.

[insert the *Excursus* table 7 here]

Implications for the diagnostic practice: Is workplace phobia an appropriate diagnosis?

Workplace phobia is associated with a very compex stimulus and therefore appears even as a *complex phobia* more than a *simple (or specific) phobia* [see also table 6]. Workplace phobia has far-reaching consequences for work-participation and thus can mean existential endangerment for the affected person. As simple phobias are usually not going along with severe work-performance problems (Greenberg et al., 1999) and thus should not provoke existential fear; the latter appears as a specific consequence of workplace phobia. Another point which makes workplace phobia appear different from simple phobia are the specific requirements in treatment.

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Due to the findings and their practical implications, it seems useful explicitely naming the phenomenon of “workplace phobia” instead of subsuming it under established anxiety diagnosis like “agoraphobia”: It makes a difference whether a person avoids leaving the own flat because of the fear to come into situations where help is not possible (agoraphobia), or whether a person avoids going out because of a possible confrontation with colleagues or superiors from the feared workplace (workplace phobia). In both cases the avoidance reactions look like the same, and implicate the diagnosis of an agoraphobia, but the psychological mechanisms lying behind are very different.

Thus, making explicit the problem of workplace phobia by naming it “workplace phobia” simply has good practical reasons. Using the ICD-10 classification, “workplace phobia” could be described with the number F 40.8 (“Other phobic disorders”).

Limitations and prospect

This is a first exploratory study which aims at investigating specific characteristics of workplace phobia. As it is a cross-sectional study, the above discussed aspects of etiology cannot be proofed with data on courses over a certain time. Beside situational aspects as possible releasing factors in workplace phobia, there are also individual personality disposition and coping strategies for overcoming work loads (Schaarschmidt & Fischer, 1997) which must be expected to play an important role in the development of workplace phobia. This perspective should be a topic for further research.

Further research should also consider the development and evaluation of work-directed psychotherapy approaches and their efficiacy concerning durable vocational reintegration. Furthermore, workplace phobia should be investigated in other clinical populations. Finally, different professional settings and the working population should be investigated for

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epidemiologic findings, and in order to identify possible preventive and risk factors for workplace phobia.

Conclusion

Workplace phobia is a severe and disabling anxiety syndrome. It is in a special way related with sick leave. Workplace phobia requires special diagnostic attention and treatment instead of purely "sick leave" certification. In medical, psychotherapeutical and socio-medical practice, using the term "workplace phobia" could be helpful for more clearly communicating this problem to colleagues.

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Table 1. Items of the Workplace Phobia Screening (WPS, original "Arbeitsplatzphobieskala").
Note: Items are rated on a scale from 0=do not agreee at all to 4= do agree totally. Persons who are currently unemployed are asked to refer to their last work situation and imagine returning there.

1. When thinking about my workplace, everything in my body is tense.
2. When imagining having to pass a complete working day at this workplace, I get feelings of panic.
3. In special situations at the workplace I am afraid of getting symptoms like trembling, blushing, sweating, heartbeating.
4. I rather take a roundabout way instead of passing the street where my workplace is situated.
5. My sleep is worse before working days in contrast to non-working-days.
6. I feel tense when entering public places (like the supermarket of my town) where I could meet colleagues or superiors.
7. Whenever possible, I avoid approaching the site of my workplace.
8. I had to go on sick leave once or for several times because I could not stand any longer the problems at my workplace.
9. On my way to my workplace I would rather turn and walk back.
10. After work I hurry up more than others just to get away from that place.
11. While working, I am always paying attention what could happen next.
12. I feel severly uncomfortable and tense when I *am at* my workplace.
13. I feel severly uncomfortable and tense when I *think of* my workplace.

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Table 2. Mini-Work-Anxiety-Interview (Mini-WAI) Section Workplace Phobia. The questions refer to the central diagnostic criteria of workplace phobia. They cover anticipatory anxiety, physiological arousal, avoidance tendencies, suffering and restrictions in work-participation.

1. When being at or thinking of your workplace in general, do you feel in special way nervous, tense and/or frightened?

2. Do you try to leave your workplace whenever possible or do you avoid going past your workplace whenever you can?

3. When thinking of your workplace in general, do you get feelings of severe anxiety, tension and nervousness?

4. When being at your workplace or thinking of it or going to your workplace, do/did you regularly have spells or attacks with:

- **skipping, racing or pounding of your heart?**
- **sweating or clammy hands?**
- **trembling or shaking?**
- **difficulty breathing?**
- **a choking sensation or a lump in your throat?**
- **chest pain, pressure or discomfort?**
- **nausea, stomach pain or sudden diarrhea?**
- **feeling dizzy, unsteady, lightheaded or faint?**
- **things around you feeling strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?**
- **fear that you were losing control or going crazy?**
- **tingling or numbness in parts of your body?**
- **hot flushes or chills?**

5. Have you felt restricted while working because of the symptoms? or Have you been suffering heavily from the symptoms?

(Workplace phobia is diagnosed when question 1. is answered yes, questions 2 or 3 is answered yes, at least 4 symptoms in question 4. are answered yes, question 5. is answered yes.)

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Table 3. Comorbidities of workplace phobia according to Mini-WAI and established anxiety disorders according to MINI in psychosomatic inpatients (*N*=230).

Note: Diagnosis of "established anxiety disorders" from the MINI are agoraphobia, panic disorder, social phobia, obsessive compulsive disorder, generalized anxiety disorder, posttraumatic stress disorder and hypochondriasis. Diagnosis of established anxiety disorders can but must not occur as comorbid diagnosis.

	Patients with workplace phobia (N=39)	**Patients without workplace phobia (N=191)**	
Patients with established anxiety disorder [N=117]	10% [19,7%] (59%)	**40,9%** [80,3%] (49,2%)	50,9% [100%]
Patients without established anxiety disorder [N=113]	**5,7%** [14,2%] (41%)	43,5% [85,8%] (50,8%)	49,1% [100%]
	17% (100%)	83% (100%)	100%

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Table 4. Self-reported general psychosomatic symptom load (SCL-90-R) and workplace phobic symptoms (Workplace-Phobia-Screening) in psychosomatic inpatients (N=230).

Note: Means (standard deviation) are reported. *P*-values are Bonferroni adjusted for minimizing type I error. Significances of difference are refering to the comparison of the groups:

a Patients with diagnosis of workplace phobia versus patients with diagnosis of established anxiety disorder

b Patients with diagnosis of workplace phobia versus patients without diagnosis of established anxiety disorder and without workplace phobia

c Patients without diagnosis of established anxiety disorders and without workplace phobia versus patients with diagnosis of established anxiety disorder

Measure of self-reported symptom load	**Patients with diagnosis of workplace phobia (N=13)**	**Patients with diagnosis of established anxiety disorder (N=94)**	**Patients with workplace phobia and established anxiety disoder (N=23)**	**Patients without established anxiety disorder and without workplace phobia (N=100)**	**Sig. of diffe-rence** ***p***
SCL Global Severity Index	1,53 (0,5)	1,3 (0,7)	1,57 (0,6)	0,97 (0,6)	[a]1.000 [b]1.000 [c].003***
SCL Somatization	1,34 (0,7)	1,33 (0,8)	1,48 (0,8)	0,97 (0,6)	[a]1.000 [b].448 [c].003***
SCL Obsessive-Compulsive	1,87 (0,7)	1,58 (0,8)	2,04 (0,8)	1,24 (0,6)	[a]1.000 [b].075 [c].040**
SCL Interpersonal Sensitivity	1,61 (0,8)	1,23 (0,9)	1,51 (0,8)	0,9 (0,7)	[a].685 [b].023** [c].043**
SCL Depression	2,21 (0,7)	1,68 (0,8)	2,03 (0,8)	1,44 (0,9)	[a].213 [b].015** [c].331
SCL Anxiety	1,5 (0,5)	1,43 (0,8)	1,85 (0,9)	1,0 (0,7)	[a]1.000 [b].075 [c].001***
SCL Hostility	1,32 (0,5)	0,98 (0,7)	1,1 (0,6)	0,72 (0,5)	[a].389 [b].007** [c].025**
SCL Phobic anxiety	0,99 (0,9)	1,05 (1,0)	1,45 (1,2)	0,53 (0,8)	[a]1.000 [b].589 [c].001***
SCL Paranoid ideation	1,54 (0,6)	1,22 (0,9)	1,27 (0,8)	0,76 (0,6)	[a].934 [b].004** [c].000***
SCL Psychotizism	0,88 (0,5)	0,78 (0,7)	0,85 (0,8)	0,54 (0,6)	[a]1.000 [b].500 [c].071

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Workplace Phobia Screening Inventory (mean score)	2,92 (0,9)	1,32 (1,1)	3,48 (0,5)	1,19 (1,1)	[a].000*** [b].000*** [c]1.000

p<.05**, *p*<.01***

Table 5. Self-reported work load, work participation, and employment status in psychosomatic inpatients (*N*=230).

Note: For the variables perceived work load and duration of sick leave means (standard deviation) are reported. For sick leave at admission and current employment status, percentages are reported.

P-values are Bonferroni adjusted for minimizing type I error.

Significances of difference are refering to the comparison of the groups:

a Patients with diagnosis of workplace phobia versus patients with diagnosis of established anxiety disorder

b Patients with diagnosis of workplace phobia versus patients without diagnosis of established anxiety disorder and without workplace phobia

c Patients without diagnosis of established anxiety disorders and without workplace phobia versus patients with diagnosis of established anxiety disorder

	Patients with diagnosis of workplace phobia (N=13)	**Patients with diagnosis of established anxiety disorder (N=94)**	**Patients with workplace phobia and established anxiety disoder (N=23)**	**Patients without established anxiety disorder and without workplace phobia (N=100)**	**Sig. of diffe-rence** ***p***
Perceived work load: „The workplace caused or forced my health problems“: rating of agreement: 0-100	73,46 (21,9)	42,33 (31,5)	81,38 (18,7)	36,27 (32,4)	[a].004*** [b].000*** [c]1.000
Duration of sick leave in the past 12 months in weeks	23,62 (12,4)	15,6 (17,4)	24,22 (19,9)	11,41 (15,11)	[a].610 [b].076 [c].471
On sick leave at admission	77%	36%	70%	33%	[a].025** [b].012** [c]1.000
Currently employed	62%	66%	65%	80%	[a]1.000 [b]1.000 [c].200

p<.05**, *p*<.01***

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Table 6. Participation in work-directed treatments in psychosomatic inpatients (*N*=230)
Note: Percentages are reported. *P*-values are Bonferroni adjusted for minimizing type I error.
Significances of difference are refering to the comparison of the groups:
a Patients with diagnosis of workplace phobia versus patients with diagnosis of established anxiety disorder
b Patients with diagnosis of workplace phobia versus patients without diagnosis of established anxiety disorder and without workplace phobia
c Patients without diagnosis of established anxiety disorders and without workplace phobia versus patients with diagnosis of established anxiety disorder

Work-directed therapies	**Patients with diagnosis of workplace phobia (N=13)**	**Patients with diagnosis of established anxiety disorder (N=94)**	**Patients with workplace phobia and established anxiety disoder (N=23)**	**Patients without established anxiety disorder and without workplace phobia (N=100)**	**Sig. of diffe-rence** *p*
Participation in work-related therapy units	100%	73%	96%	69%	[a].209 [b].090 [c]1.000
Conflict management	15%	22%	22%	17%	[a]1.000 [b]1.000 [c]1.000
Work application training	54%	12%	22%	5%	[a].000*** [b].000*** [c].854
Time management	0%	11%	4%	10%	[a]1.000 [b]1.000 [c]1.000
Workplace as main topic in sociotherapy (consultations with the social worker)	85%	48%	83%	43%	[a].090 [b].038** [c]1.000
Workplace as main topic in psychotherapy (consultat. with psychotherapist)	77%	28%	52%	39%	[a].003*** [b].041** [c].630
Professional capacity test ("practical working trial" in hospitation workplaces)	0%	4%	9%	4%	[a]1.000 [b]1.000 [c]1.000

p<.05**, *p*<.01***

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Table 7. *Excursus:* "The workplace caused my mental problems" - Workplace phobia as a "Pathological Realangst"

Patients with *workplace phobia* had a significantly higher perception of "work load", i.e. perceived negative influence on the person´s health state, than those patients without workplace phobia. Patients without workplace phobia, whether affected from an established anxiety disorder or not, did not show significant differences concerning work load perception (table 5). Patients with workplace phobia are highly convinced that the workplace had negative influence on their health status. This can be seen as an evidence for the perception of the workplace as a "real" endangering stimulus. *People know why they are frightened at work*, namely because of ugly working conditions, frightening superiors, aggressive cumstomers, or the daily work overload etc. Therefore workplace phobia can also be understood as a form of *"Pathological Realangst"* (Linden, Dirks, & Glatz, 2008) which means a *dysfunctional (pathological) anxiety reaction while a realistic endangering stimlus is present.* This is another evidence for the specific clinical value of workplace phobia, which makes it distinguishable from other (established) anxiety disorders, especially specific phobias which require as a diagnostic criterion that the fear is perceived as "exaggerated" or "senseless" by the person him- or herself (APA, 1994).

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